

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>IN005245</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>03/26/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>VISITING NURSE AND HOSPICE HOME INC</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>5910 HOMESTEAD RD FORT WAYNE, IN 46814</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	<p>Initial Comments</p> <p>This was a Home Health state licensure survey.</p> <p>Survey Dates: March 22, 25, and 26, 2013</p> <p>Facility Number: IN005245</p> <p>Medicaid Number: 100272130A</p> <p>Surveyor: Miriam Bennett, RN, BSN, PHNS</p> <p>Census Service Type: Skilled: 122 Home Health Aide Only: 0 Personal Services Only: 0 Total: 122</p> <p>Sample: RR w/HV: 3 RR w/o HV: 2 Total: 5</p> <p>Visiting Nurse and Hospice Home is in compliance with the Indiana state rules for home health agency licensure 410 IAC Article 17.</p> <p>Quality Review: Joyce Elder, MSN, BSN, RN March 27, 2013</p>	N 000		

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1